Attachment Form for Electronically Submitted Claims

Provider Information

Rendering Provider Number _____

Provider Phone Number _____

Provider Fax Number _____

Provider Name _____

Provider Street/Mailing Address _____

Provider Contact Name _____

City _____

State _____

Zip _____

Provider Contact Number _____

Member Information

Member Medicaid ID Number _____

Member Name _____

Member Date of Birth _____

Claim Information

Transaction Control Number (TCN) _____

Bill Date _____

HIPAA Attachment Code _____

Date of Service Related to Attachment _____

Procedure Code Related to Attachment _____